GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINISTRATION

CHIROPRACTIC
NEW LICENSE APPLICATION

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514. If you have any questions, call HPLA Customer Service at **1-888-204-6193**, Monday through Friday, 8AM to 5PM EST.

SECTION 1. TYPE OF LICENSE

Check the box next to the type of license for which you are applying.

Pre-licensing Education

☐	CH – Chiropractic	$568
☐	CH – Chiropractic Non-Invasive Ancillary Procedures	$297
☐	CH / ANC – Chiropractic License with Ancillary Procedures	$865
☐	Ancillary Re-exam	$111
☐	Chiropractic Re-exam	$111
☐	**Duplicate Licenses (limit 5) _____ X $34.00 =**	**$_____.00**
	Total Enclosed	**$_____.00**

Make check or money order payable to DC Treasurer.
A charge of $65.00 will be imposed for dishonored checks (public Law 89-208).

MAIL TO:
Department of Health
Health Professional Licensing Administration
717 – 14th St NW
Suite 600
Washington, DC 20005

Check $	HPLA Check #	Staff
$ __ __ __.00		

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, you must provide a copy of legal name change documents for EACH time that it has changed. Complete Section 4 of this application on page 2.

FIRST NAME | MI | LAST NAME | SUFFIX (Jr, Sr, etc.)

SOCIAL SECURITY NUMBER*
If applicant does not provide a social security number, a sworn affidavit is required.

PLACE OF BIRTH
Provide City and State for US birthplace or Country for foreign place of birth.

M M – D D – Y Y Y Y
DATE OF BIRTH

☐ Male ☐ Female
GENDER
Please check the correct box.

SECTION 3. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Medicine. Keep a photocopy of all supporting documents for your records.

			HPLA ONLY
A.	Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.	YES ☐ NO ☐	
B.	Three (3) characters reference forms.	YES ☐ NO ☐	☐
C.	Verification(s) of licensure – These should be provided in a sealed envelope from the issuing jurisdiction for each license identified in Section 6C.	YES ☐ NO ☐	☐
D.	All undergraduate, graduate, medical, and profession school transcripts. These transcripts should be provided in a sealed envelope from the issuing institution for each of the schools that you attended and listed in Section 6A.	YES ☐ NO ☐	☐
E.	Documentation of all experience following graduation from medical/professional school. Proof of experience should be submitted as a letter from the overseeing institution/organization.	YES ☐ NO ☐	☐
F.	Examination scores – These should be provided in a sealed envelope from the NBCE.	YES ☐ NO ☐	☐

* Under the authority of Public Law 93-579, section (b), the Department of Health requests your Social Security Number/FEIN to assist in the administration of D.C. tax laws. Disclosure is not required as a part of the licensing process and will not be made available to the public.

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SECTION 4. PREVIOUS NAME CHANGE

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

SECTION 5A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY STATE ZIP CODE + 4

HOME PHONE NUMBER HOME FAX NUMBER E-MAIL ADDRESS

SECTION 5B. BUSINESS ADDRESS

Please note: This information will be made available to the public.

COMPANY NAME

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY STATE ZIP CODE + 4

BUSINESS PHONE NUMBER BUSINESS FAX NUMBER E-MAIL ADDRESS

SECTION 5C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☐ HOME ☐ BUSINESS

SECTION 6A. PROFESSIONAL SCHOOLS ATTENDED

List all colleges and universities attended prior to and including medical/professional schools. List schools attended in reverse chronological order, with the most recent at the top.

School Name, City, State, Country	Number of Hours Completed	Date of Graduation	Type of Degree/Certificate

SECTION 6B. MEDICAL/PROFESSIONAL TRAINING AND MEDICAL/PROFESSIONAL PRACTICE

List all experience since medical/professional school graduation below. Include letters from employing facilities and organizations for internships, residencies, fellowships or employment. For "Description", use the letter from the key below. List experience in reverse chronological order, beginning with the most recent. Attach a typed sheet if more space is needed.

Organization/Institution	Start Date	End Date	Description (Use Key Below)*

*** TRAINING AND PRACTICE DESCRIPTIONS**

A. Fellowship
B. Internship
C. Residency
D. Apprenticeship
E. Employment
F. Private Practice
G. Other (Attach a typed explanation on a separate sheet of paper to this form.)

SECTION 6C. MEDICAL/PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS

Are you now or have you ever been licensed in DC or any other state/jurisdiction? YES ☐ NO ☐

(If "Yes", be sure to complete section 6C of this form.) You must request verification of licensure for all of these licenses, past and/or present.

Jurisdiction	Date License Was First Obtained	License Number

SECTION 7. SCREENING QUESTIONS – Applicants MUST answer all of the following questions.

All applicants must complete ALL questions. ***If you answer "Yes" to any of the questions B through J below, please provide a complete explanation on a separate sheet of paper and attach with this application form.***

HPLA ONLY

A. Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.

Please read the information below carefully before responding to this yesor no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of ColumbiaGovernment as a result of any of the following: Yes ☐ No ☐ — YES ☐ NO ☐

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (LitterControl Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Actof 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

			HPLA ONLY
B.	Have you ever been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	YES ☐ NO ☐	☐
C.	Are you now or have you ever been licensed in DC or any other state/jurisdiction? *(If "Yes," be sure to complete section 6C of this form.)*	YES ☐ NO ☐	☐
D.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES ☐ NO ☐	☐
E.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	YES ☐ NO ☐	☐
F.	Have you ever been terminated from or resigned from a clinical or professional training program?	YES ☐ NO ☐	☐
G.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES ☐ NO ☐	☐
H.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	YES ☐ NO ☐	☐
I.	(1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority, health facility or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority, health facility or peer review board for any violation of state, federal, or local law? (4) Has any authority, health facility or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	YES ☐ NO ☐	☐
J.	Have you ever been terminated or asked to resign from employment since obtaining your (professional) license?	YES ☐ NO ☐	☐

Please be sure to complete the affidavit of application below.

All applications that are unsigned by the applicant will be returned unprocessed.

SECTION 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

LICENSEE SIGNATURE	NAME (Please Print)	DATE	HPLA ONLY
			☐

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.